

December 18, 2014

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Burwell:

We appreciate the opportunity to comment on the proposed amendment to the Arizona Health Care Cost Containment System demonstration project submitted to the Centers for Medicare & Medicaid Services. Our comments address two of the proposed amendments – the request to charge a \$200 copay for use of the emergency room in non-emergency situations and the request to impose premiums on people with incomes between 100 and 138 percent of the poverty line. These amendments raise concerns that should be addressed during the approval process to avoid barriers for people seeking to enroll in coverage or get health care services.

Arizona’s request to impose a mandatory \$200 co-pay on people who receive health care services for non-emergencies at the emergency room is beyond the scope of section 1115 waiver authority.

Arizona’s request to impose a \$200 mandatory co-pay on people who use the emergency room (ER) in non-emergency situations does not represent an appropriate use of section 1115 waiver authority, because section 1115 does not provide authority to waive the cost-sharing provisions in section 1916 of the Social Security Act. Waivers of cost-sharing provisions can only be approved under the separate waiver authority in section 1916(f). A state requesting such a waiver must show that its proposal meets the following criteria:

1. The state’s proposal will test a previously untested use of copayments;
2. The waiver period will not exceed two years;
3. The benefits to enrollees are reasonably equivalent to the risks;
4. The proposal is based on a reasonable hypothesis and will be tested in a methodologically sound manner; and
5. Beneficiary participation is voluntary.

Arizona’s proposal does not address any of these criteria, and for this reason it should be denied. It is also questionable whether such a high co-pay would ever promote the objectives of Medicaid given the large body of research – going back to the 1970s – demonstrating the harmful effects cost sharing has on utilization of care for low-income people, including the impact on appropriate use of care *and* health outcomes. Cost sharing also poses significant financial strain on individuals who have limited resources.

Moreover, a 1916(f) waiver is not necessary given the considerable flexibility states already have to impose cost sharing through a state plan amendment. As you know, current federal regulations permit states to target cost sharing to specific groups with income above the

federal poverty line. Under existing federal regulations, individuals with incomes above the poverty line could be subject to co-pays that equal 10 percent of the cost a state pays for outpatient services and inpatient hospital stays. States could even submit a State plan amendment to require individuals with incomes above the poverty line to pay cost sharing as a condition for receiving care. While we remain concerned that these policy choices may prevent individuals from seeking needed care, the fact of the matter is that they are currently available to states through the Medicaid State plan.

Finally, to the extent that Arizona does impose a co-pay for non-emergent use of the ER, CMS should ensure that the state complies with provisions of the Deficit Reduction Act that relate to co-pays for non-emergent use of the ER. Specifically, Arizona must ensure that alternative non-emergency providers are available and accessible to the Medicaid beneficiary seeking care, and that before non-emergency care is provided at the ER, the beneficiary is informed of the co-pay and the availability of alternative care providers.

Arizona's request to impose premiums is vague and lacks sufficient detail.

Given the longstanding and robust body of evidence showing the negative effects premiums have on low-income beneficiaries, we remain concerned that imposing premiums on individuals with incomes between 100 and 133 percent of the federal poverty level will deter enrollment and decrease participation in coverage. We are particularly troubled by the lack of detail in the state's proposal. The proposal does not include the exact premium amounts, how they will be determined, and the consequences of nonpayment for beneficiaries. For example, while the proposal states that premiums will not exceed two percent of a person's household income, it is unclear whether the state will impose a premium calculated at two percent for all affected individuals or implement a sliding scale based on income that ends with premiums calculated at two percent of income for those at the top end of the scale. If permitted, premium amounts should be specified in the special terms and conditions.

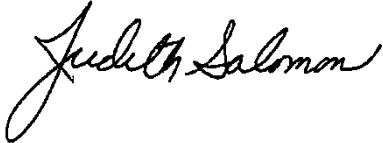
It is also unclear from Arizona's proposal how it would determine the amount of the premiums beneficiaries must pay. The proposal does not specify whether monthly, quarterly, or annual income will be used to determine premium payments. The special terms and conditions should describe how the state will determine monthly premiums.

In order to ensure that Arizona's request does not create additional barriers to coverage, CMS should also stipulate in the special terms and conditions that the state cannot terminate coverage for failure to pay monthly premiums, as CMS did when approving premiums in Iowa and Michigan. At the very least, we urge CMS to provide a 90-day premium grace period and prohibit Arizona from denying individuals the opportunity to re-enroll due to nonpayment of premium for a prior period as CMS recently did in Pennsylvania.

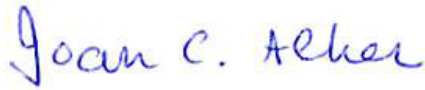
Finally, premiums and cost sharing should be subject to a monthly or quarterly aggregate cap of 5 percent of family income. This is a longstanding beneficiary protection that CMS has included in all recently approved expansion demonstrations.

Thank you for the opportunity to share our views. Please contact Judith Solomon at solomon@cbpp.org or Joan Alker at jca25@georgetown.edu if you would like additional information.

Yours truly,

A handwritten signature in black ink that reads "Judith Solomon". The signature is written in a cursive style with a large, looping initial "J".

Judith Solomon,
Vice President, Health Policy
Center on Budget and Policy Priorities

A handwritten signature in blue ink that reads "Joan C. Alker". The signature is written in a cursive style with a large, looping initial "J".

Joan Alker
Executive Director
Georgetown University Center for Children and Families